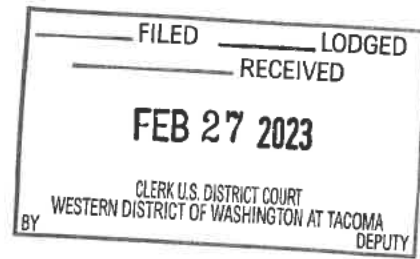


Pro Se 7 2016



UNITED STATES DISTRICT COURT  
WESTERN DISTRICT OF WASHINGTON

Tiffany Recinos

CASE NO. 3:23-CV-05154-DGE  
[to be filled in by Clerk's Office]

COMPLAINT FOR EMPLOYMENT  
DISCRIMINATION

Plaintiff(s),

Jury Trial: ☐ Yes ☐ No

v.

Maxim Healthcare  
Purge Steeves, Rachael  
McMeel, Robyn

Defendant(s).

**I. THE PARTIES TO THIS COMPLAINT**

**A. Plaintiff(s)**

*Provide the information below for each plaintiff named in the complaint. Attach additional pages if needed.*

Name

Tiffany Recinos

Street Address

19212 205th St E.

City and County

Orting, Pierce County

State and Zip Code

WA, 98360

Telephone Number

(360) 932-6316

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## B. Defendant(s)

Provide the information below for each defendant named in the complaint, whether the defendant is an individual, a government agency, an organization, or a corporation. For an individual defendant, include the person's job or title (if known). Attach additional pages if needed.

## Defendant No. 1

Name

Job or Title (if known)

Street Address

City and County

State and Zip Code

Telephone Number

Maxim Healthcare

EMPLOYER

7227 Lee DeForest Dr.

Columbia

MD, 21046

## Defendant No. 2

Name

Job or Title (if known)

Street Address

City and County

State and Zip Code

Telephone Number

Parge Steeves

ESIS

parge.steeves@esis.com

## Defendant No. 3

Name

Job or Title (if known)

Street Address

City and County

State and Zip Code

Telephone Number

Rachael McMeel

Supervisor Industrial Insurance

mcmr235@LNT.WA.GOV  
(360) 902-6107

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Defendant No. 4

Name

Robyn

Job or Title (if known)

maxim Boss that fired me

Street Address

City and County

State and Zip Code

Telephone Number

## C. Place of Employment

The address at which I sought employment or was employed by the defendant(s) is:

Name

Maxim Healthcare

Street Address

City and County

Tacoma, Pierce County

State and Zip Code

WA

Telephone Number

## II. BASIS FOR JURISDICTION

This action is brought for discrimination in employment pursuant to (check all that apply):



Title VII of the Civil Rights Act of 1964, as codified, 42 U.S.C. §§ 2000e to 2000e-17 (race, color, gender, religion, national origin).

(Note: In order to bring suit in federal district court under Title VII, you must first obtain a Notice of Right to Sue letter from the Equal Employment Opportunity Commission.)



Age Discrimination in Employment Act of 1967, as codified, 29 U.S.C. §§ 621 to 634.

(Note: In order to bring suit in federal district court under the Age Discrimination in Employment Act, you must first file a charge with the Equal Employment Opportunity Commission.)

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☒ Americans with Disabilities Act of 1990, as codified, 42 U.S.C. §§ 12112 to 12117.

(Note: In order to bring suit in federal district court under the Americans with Disabilities Act, you must first obtain a Notice of Right to Sue letter from the Equal Employment Opportunity Commission.)

☒ Other federal law (specify the federal law):

Rehabilitation Act of 1973

☐ Relevant state law (specify, if known):

☐ Relevant city or county law (specify, if known):

### III. STATEMENT OF CLAIM

Write a short and plain statement of the claim. Do not make legal arguments. State as briefly as possible the facts showing that each plaintiff is entitled to the damages or other relief sought. State how each defendant was involved and what each defendant did that caused the plaintiff harm or violated the plaintiff's rights, including the dates and places of that involvement or conduct. If more than one claim is asserted, number each claim and write a short and plain statement of each claim in a separate paragraph. Attach additional pages if needed.

Maxim terminated my employment 10/2021 for not immunizing (covid19) I then immunized 11/21 and 12/21 to not get re-employed. Now I have autoimmune disorder from immunization and can not work as RN without work history since 10/2021.

A. The discriminatory conduct of which I complain in this action includes (check all that apply):

- ☒ Failure to hire me.
- ☒ Termination of my employment.
- ☐ Failure to promote me.
- ☒ Failure to accommodate my disability.
- ☐ Unequal terms and conditions of my employment.
- ☒ Retaliation.



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☐ Other acts (specify): \_\_\_\_\_

B. It is my best recollection that the alleged discriminatory acts occurred on date(s)

October 31<sup>st</sup> 2021 - terminated my employment!

C. I believe that defendant(s) (check one):

☒ is/are still committing these acts against me.

☐ is/are not still committing these acts against me.

D. Defendant(s) discriminated against me based on my (check all that apply and explain):

☐ race

☐ color

☐ gender/sex

☒ religion

☐ national origin

☐ age (year of birth)

(only when asserting  
a claim of age  
discrimination.)

☒ disability or perceived disability (specify disability)

on SSDI for PTSD.

I had an approved religious exemption  
to avoid immunization.

E. The facts of my case are as follows. Attach additional pages if needed.

I had an approved exemption from immunization yet  
I still got fired for not immunizing no other  
proof of "just cause termination" exists.

(Note: As additional support for the facts of your claim, you may attach to this complaint  
a copy of your charge filed with the Equal Employment Opportunity Commission, or the charge  
filed with the relevant state or city human rights division.)

Robyn, boss at Maxim, stated she fired me  
for just cause. I want proof! I did  
nothing wrong! Interviews deny me job placement  
because they say something is popping up in  
my files making me unhireable. So I can  
not secure an RN job now its over a year with  
COMPLAINT FOR EMPLOYMENT DISCRIMINATION - 5 NO RN WORK HISTORY SO  
no one will hire me

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**IV. EXHAUSTION OF FEDERAL ADMINISTRATIVE REMEDIES**

- A. It is my best recollection that I filed a charge with the Equal Employment Opportunity Commission or my Equal Employment Opportunity counselor regarding the defendant's alleged discriminatory conduct on (date)

N/A

- B. The Equal Employment Opportunity Commission (check one):

- ☒ has not issued a Notice of Right to Sue letter.  
☐ issued a Notice of Right to Sue letter, which I received on (date)

N/A

(Note: Attach a copy of the Notice of Right to Sue letter from the Equal Employment Opportunity Commission to this complaint.)

- C. Only litigants alleging age discrimination must answer this question.

Since filing my charge of age discrimination with the Equal Employment Opportunity Commission regarding the defendant's alleged discriminatory conduct (check one):

- N/A ☐ 60 days or more have elapsed.  
☐ less than 60 days have elapsed.

**V. RELIEF**

State briefly and precisely what damages or other relief the plaintiff asks the court to order. Do not make legal arguments. Include any basis for claiming that the wrongs alleged are continuing at the present time. Include the amounts of any actual damages claimed for the acts alleged and the basis for these amounts. Include any punitive or exemplary damages claimed, the amounts, and the reasons you claim you are entitled to actual or punitive money damages.

- ① Back pay to date of termination 10-31-2021 @ \$35/hourly for 40 hours per week night shift. And settlement offer.  
 ② Re-employment into new career field.  
 ③ See RN Stipulation on MSE Sys from 2010.

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## VI. CERTIFICATION AND CLOSING

Under Federal Rule of Civil Procedure 11, by signing below, I certify to the best of my knowledge, information, and belief that this complaint: (1) is not being presented for an improper purpose, such as to harass, cause unnecessary delay, or needlessly increase the cost of litigation; (2) is supported by existing law or by a nonfrivolous argument for extending, modifying, or reversing existing law; (3) the factual contentions have evidentiary support or, if specifically so identified, will likely have evidentiary support after a reasonable opportunity for further investigation or discovery; and (4) the complaint otherwise complies with the requirements of Rule 11.

I agree to provide the Clerk's Office with any changes to my address where case-related papers may be served. I understand that my failure to keep a current address on file with the Clerk's Office may result in the dismissal of my case.

Date of signing:

Signature of Plaintiff

Printed Name of Plaintiff

Tiffany Recinos  
Tiffany Recinos

Date of signing:

Signature of Plaintiff

Printed Name of Plaintiff

02-27-23  
Tiffany Recinos  
Tiffany Recinos

Date of signing:

Signature of Plaintiff

Printed Name of Plaintiff



**FORM SSA-1099 – SOCIAL SECURITY BENEFIT STATEMENT****2022**

• PART OF YOUR SOCIAL SECURITY BENEFITS SHOWN IN BOX 5 MAY BE TAXABLE INCOME.  
 • SEE THE REVERSE FOR MORE INFORMATION.

|   |   |  |
|---|---|--|
| Box 1. Name<br><b>JASON RECINOS</b>   |   | Box 2. Beneficiary's Social Security Number<br><b>[REDACTED]</b>                                       |
| Box 3. Benefits Paid in 2022<br><br>\$5,095.00  | Box 4. Benefits Repaid to SSA in 2022<br><br>NONE | Box 5. Net Benefits for 2022 (Box 3 minus Box 4)<br><br>\$5,095.00                                     |
| <b>DESCRIPTION OF AMOUNT IN BOX 3</b><br><br>Paid by check or Direct deposit \$5,095.00<br>Benefits for 2022 \$5,095.00 |   | <b>DESCRIPTION OF AMOUNT IN BOX 4</b><br><br>NONE  |
|   |   | Box 6. Voluntary Federal Income Tax Withheld<br><br>NONE   |
|   |   | Box 7. Address<br>TIFFANY RECINOS FOR<br><b>[REDACTED]</b><br>19212 205TH ST E<br>ORTING WA 98360-9355 |
|   |   | Box 8. Claim Number (Use this number if you need to contact SSA.)<br><br><b>[REDACTED]</b>             |

Form SSA-1099-SM (1-2023)

**DO NOT RETURN THIS FORM TO SSA OR IRS**

IMPORTANT: TAX INFORMATION ENCLOSED  
 KEEP THIS FORM FOR PROOF OF SOCIAL SECURITY BENEFITS

**SCAM ALERT**

Scammers are pretending to be government employees. They may threaten you and may demand immediate payment to avoid arrest or other legal action. Do not be fooled!

If you receive a suspicious call:

1. HANG UP!
2. DO NOT GIVE THEM MONEY OR PERSONAL INFORMATION!
3. REPORT THE SCAM AT [OIG.SSA.GOV](https://www.oig.ssa.gov)



**FORM SSA-1099 – SOCIAL SECURITY BENEFIT STATEMENT****2022**

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 • SEE THE REVERSE FOR MORE INFORMATION.

|   |   |   |
|---|---|---|
| Box 1. Name<br><b>CONNOR E RECINOS</b>  |   | Box 2. Beneficiary's Social Security Number<br><b>[REDACTED]</b>                                |
| Box 3. Benefits Paid in 2022<br><br>\$5,095.00  | Box 4. Benefits Repaid to SSA in 2022<br><br>NONE | Box 5. Net Benefits for 2022 (Box 3 minus Box 4)<br><br>\$5,095.00                              |
| <b>DESCRIPTION OF AMOUNT IN BOX 3</b><br><br>Paid by check or Direct deposit \$5,095.00<br>Benefits for 2022 \$5,095.00 |   | <b>DESCRIPTION OF AMOUNT IN BOX 4</b><br><br>NONE   |
|   |   | Box 6. Voluntary Federal Income Tax Withheld<br><br>NONE  |
|   |   | Box 7. Address<br>TIFFANY RECINOS FOR<br>[REDACTED]<br>19212 205TH ST E<br>ORTING WA 98360-9355 |
|   |   | Box 8. Claim Number (Use this number if you need to contact SSA.)<br><br>[REDACTED]             |

Form SSA-1099-SM (1-2023)

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**FORM SSA-1099 – SOCIAL SECURITY BENEFIT STATEMENT**

|   |   |  |
|---|---|--|
| <b>2022</b> • PART OF YOUR SOCIAL SECURITY BENEFITS SHOWN IN BOX 5 MAY BE TAXABLE INCOME.<br>• SEE THE REVERSE FOR MORE INFORMATION.  |   |  |
| Box 1. Name<br>TIFFANY D RECINOS  |   | Box 2. Beneficiary's Social Security Number<br>                         |
| Box 3. Benefits Paid in 2022<br>\$20,379.30   | Box 4. Benefits Repaid to SSA in 2022<br>NONE | Box 5. Net Benefits for 2022 (Box 3 minus Box 4)<br>\$20,379.30  |
| <b>DESCRIPTION OF AMOUNT IN BOX 3</b><br>Paid by check or Direct deposit \$20,379.30<br>Medicare Part B premiums deducted from your benefits \$510.30<br>Total Additions \$20,889.60<br>SUBTRACT<br>Non-Taxable payments \$510.30<br>Total Subtractions \$510.30<br>Benefits for 2022 \$20,379.30 |   | <b>DESCRIPTION OF AMOUNT IN BOX 4</b><br>NONE  |
|   |   | Box 6. Voluntary Federal Income Tax Withheld<br>NONE   |
|   |   | Box 7. Address<br>TIFFANY D RECINOS<br>19212 205TH ST E<br>ORTING WA 98360-9355  |
|   |   | Box 8. Claim Number (Use this number if you need to contact SSA.)<br> |

Form SSA-1099-SM (1-2023)

**DO NOT RETURN THIS FORM TO SSA OR IRS**

IMPORTANT: TAX INFORMATION ENCLOSED  
 KEEP THIS FORM FOR PROOF OF SOCIAL SECURITY BENEFITS

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2. DO NOT GIVE THEM MONEY OR PERSONAL INFORMATION!
3. REPORT THE SCAM AT [OIG.SSA.GOV](https://www.oig.ssa.gov)





*Order of Reconsideration Appeals*

STATE OF WASHINGTON  
DEPARTMENT OF LABOR AND INDUSTRIES  
PO BOX 44892, OLYMPIA, WASHINGTON 98504-4892

December 12, 2022

TIFFANY RECINOS  
19212 205TH ST  
ORTING WA 98360-9355

CLAIM NUMBER SY67268  
INJURY DATE 06/10/2022  
DATE OF BIRTH 11/23/1978  
CLAIMANT RECINOS  
TIFFANY D

Dear Ms. Recinos:

I received your claim for the injury of 6/10/2022.

*Date changed*

Your claim has been rejected because it doesn't fit the criteria for claim allowance.

Your claim is not allowable as an injury because medical records were not received to determine causal relationship.

If you disagree with this decision, your written protest must be received within 60 days from the date you receive the order. Please put your claim number on each page. The instructions for filing a protest or appeal are on the order being mailed under separate cover.

Sincerely,

Rachael Mcmeel  
Wkrs Cmp Adj 4  
Self-Insurance Section  
Phone: (360) 902-6107

ORIG: WORKER - TIFFANY RECINOS  
CC: EMPLOYER - MAXIM HEALTHCARE SERVICES INC, % ESIS INC

*SI trainer question @ LNI.wa.gov.*

*Chelsey Russell*

*Boyle Law*

*\*Employment Law Attorney*

235001100058320100000000

FROM:  
STATE OF WASHINGTON  
DEPARTMENT OF LABOR AND INDUSTRIES  
DIVISION OF INDUSTRIAL INSURANCE  
SELF-INSURANCE SECTION  
PO BOX 44892  
OLYMPIA WA 98504-4892  
FAX (360) 902-6900

MAILING DATE: 12/12/22  
CLAIM ID : SY67268  
CLAIMANT : TIFFANY RECINOS  
EMPLOYER : MAXIM HEALTHCARE SER  
INJURY DATE : 6/10/22  
SERVICE LOC : TACOMA  
UBI NUMBER : 601-407-644  
ACCOUNT ID : 706220-00  
RISK CLASS : 7104-01

WORK LOCATION ADDRESS:  
NO ADDRESS REPORTED

TIFFANY RECINOS  
19212 205TH ST  
ORTING WA 98360-9355

### ORDER AND NOTICE (SELF INSURING EMPLOYER)

\*\*\*\*\*  
\*  
\* THIS ORDER BECOMES FINAL 60 DAYS FROM THE DATE IT IS COMMUNICATED \*  
\* TO YOU UNLESS YOU DO ONE OF THE FOLLOWING: FILE A WRITTEN REQUEST \*  
\* FOR RECONSIDERATION WITH THE DEPARTMENT OR FILE A WRITTEN APPEAL \*  
\* WITH THE BOARD OF INDUSTRIAL INSURANCE APPEALS. IF YOU FILE FOR \*  
\* RECONSIDERATION, YOU SHOULD INCLUDE THE REASONS YOU BELIEVE THIS \*  
\* DECISION IS WRONG AND SEND IT TO: DEPARTMENT OF LABOR AND \*  
\* INDUSTRIES, PO BOX 44892, OLYMPIA, WA 98504-4892. WE WILL REVIEW \*  
\* YOUR REQUEST AND ISSUE A NEW ORDER. IF YOU FILE AN APPEAL, SEND \*  
\* IT TO: BOARD OF INDUSTRIAL INSURANCE APPEALS, PO BOX 42401, \*  
\* OLYMPIA WA 98504-2401 OR SUBMIT IT ON AN ELECTRONIC FORM FOUND AT \*  
\* HTTP://WWW.BIIA.WA.GOV/. \*  
\*  
\*\*\*\*\*

This claim is denied. In accordance with WAC 296-20-124 any bills for services or treatment regarding this claim are rejected except those used to make this decision.

This claim is denied because:

No licensed physician's report or medical proof has been filed as required by law.

The worker's condition is not the result of the injury alleged.



MAILING DATE: 12/12/22  
CLAIM ID : SY67268  
CLAIMANT : TIFFANY RECINOS  
EMPLOYER : MAXIM HEALTHCARE SER  
INJURY DATE : 6/10/22  
SERVICE LOC : TACOMA  
UBI NUMBER : 601-407-644  
ACCOUNT ID : 706220-00  
RISK CLASS : 7104-01

WORK LOCATION ADDRESS:  
NO ADDRESS REPORTED

RACHAEL MCMEEL  
WKRS CMP ADJ 4  
SELF INSURANCE SECTION  
PO BOX 44892  
OLYMPIA, WA 98504-4892  
(360) 902-6107  
FAX #: (360) 902-6900

ORIG: CLAIMANT: TIFFANY RECINOS  
19212 205TH ST, ORTING WA, 98360-9355

EMPLOYER: MAXIM HEALTHCARE SERVICES INC  
C/O ESIS INC, 12909 SW 68TH PARKWAY STE 450,  
PORTLAND OR, 97223  
ATTENDING PHYSICIAN: TAYLOR STEVEN L MD  
SEA MAR COMMUNITY HEALTH CENTE, PO BOX 34703,  
SEATTLE WA, 98124-1703  
EMPLOYER'S ATTORNEY: -(COPY NOT SENT)

STATE OF WASHINGTON  
DEPARTMENT OF LABOR AND INDUSTRIES  
DIVISION OF INDUSTRIAL INSURANCE  
SELF INSURANCE SECTION  
PO BOX 44892  
OLYMPIA, WA 98504-4892

MAILING DATE 02/03/2023  
CLAIM NUMBER SY67268  
INJURY DATE 06/10/2022  
CLAIMANT RECINOS  
TIFFANY D  
EMPLOYER MAXIM HEALTHCAR  
UBI NUMBER 601 407 644  
ACCOUNT ID 706, 220-00  
RISK CLASS 7104  
SERVICE LOC Tacoma

TIFFANY RECINOS  
19212 205TH ST  
ORTING WA 98360-9355

NOTICE OF DECISION

We are reconsidering the order of 12/12/2022 and will issue a new order after further review.

SUPERVISOR OF INDUSTRIAL INSURANCE  
By Rachael Mcmeel  
Wkrs Cmp Adj 4  
Self-Insurance Section  
(360) 902-6107

MAILED TO: WORKER - TIFFANY RECINOS  
19212 205TH ST, ORTING WA 98360-9355  
EMPLOYER - MAXIM HEALTHCARE SERVICES INC, % ESIS INC  
12909 SW 68TH PARKWAY STE 450, PORTLAND OR 97223  
PROVIDER - TAYLOR STEVEN L MD  
SEA MAR COMMUNITY HEALTH CENTE, PO BOX 34703, SEATTLE WA 98

THIS ORDER BECOMES FINAL 60 DAYS FROM THE DATE IT IS COMMUNICATED TO YOU UNLESS YOU DO ONE OF THE FOLLOWING: FILE A WRITTEN REQUEST FOR RECONSIDERATION WITH THE DEPARTMENT OR FILE A WRITTEN APPEAL WITH THE BOARD OF INDUSTRIAL INSURANCE APPEALS. IF YOU FILE FOR RECONSIDERATION, YOU SHOULD INCLUDE THE REASONS YOU BELIEVE THIS DECISION IS WRONG AND SEND IT TO: DEPARTMENT OF LABOR AND INDUSTRIES, PO BOX 44892, OLYMPIA, WA 98504-4892. WE WILL REVIEW YOUR REQUEST AND ISSUE A NEW ORDER. IF YOU FILE AN APPEAL, SEND IT TO: BOARD OF INDUSTRIAL INSURANCE APPEALS, PO BOX 42401, OLYMPIA WA 98504-2401 OR SUBMIT IT ON AN ELECTRONIC FORM FOUND AT [HTTP://WWW.BIIA.WA.GOV/](http://WWW.BIIA.WA.GOV/).

STATE OF WASHINGTON  
BOARD OF INDUSTRIAL INSURANCE APPEALS  
2430 CHANDLER COURT SW  
PO BOX 42401  
OLYMPIA WA 98504-2401



492-1

CL1

492

TIFFANY D. RECINOS  
19212 205TH ST  
ORTING, WA 98360-9355

EM1

MAXIM HEALTHCARE SERVICES, INC.  
7227 LEE DEFOREST DR  
COLUMBIA, MD 21046

ELR1

ESIS WC CLAIMS  
MAXIM HEALTHCARE SERVICES, INC.  
12909 SW 68TH PARKWAY #450  
PORTLAND, OR 97223

**BEFORE THE BOARD OF INDUSTRIAL INSURANCE APPEALS  
STATE OF WASHINGTON**

2430 Chandler Court SW, P O Box 42401  
Olympia, Washington 98504-2401 • [www.biia.wa.gov](http://www.biia.wa.gov)  
(360) 753-6823



492-2

In re: **TIFFANY D. RECINOS**

Claim No. SY-67268

Docket No. 23 11418

**NOTICE OF RECEIPT OF APPEAL  
FROM CLAIMANT (2/13/2023)**

**This notice is for your information only. You do not need to take any action at this time.**

A Notice of Appeal has been filed with the Board of Industrial Insurance Appeals regarding the Department of Labor and Industries order dated December 12, 2022.

The Department of Labor and Industries has the right to reconsider or change its decision.

- If L&I reconsiders or changes its decision, we will return the case to L&I. All parties may appeal further L&I decisions.
- If L&I does not reconsider or change its decision, we will issue an order granting or denying this appeal.

Information about this appeal may be subject to public disclosure. For additional public disclosure information you can contact: Public Records Office, Board of Industrial Insurance Appeals, PO Box 42401 Olympia WA 98504-2401 (360) 753-6823.

If you have questions, contact the New Appeals Section at (360) 753-6823.

Dated February 13, 2023.

Visit our website at [www.biia.wa.gov](http://www.biia.wa.gov) for information on the appeal process. You will find an instructional video, a list of frequently asked questions, and our publications *Your Right to be Heard* and *Rules of Practice and Procedure*.